RANDALL J. ROGALSKY, MD

ORTHOPEDICS

TODAY'S DATE: _____

NAME _____ DATE OF BIRTH _____AGE _____

ADDRESS _____ REFERRING PHYSICIAN _____

CITY _____ OTHER PHYSICIANS _____

STATE _____ ZIP _____ SOCIAL SECURITY NO._____

HOME PHONE _____ OCCUPATION _____

CELL PHONE _____ EMPLOYER'S NAME _____

EMAIL ADDRESS _____ EMPLOYER ADDRESS/PHONE _____

PHARMACY _____ _____

_____

MARITAL STATUS (Circle One) SINGLE MARRIED DIVORCED SEPARATED WIDOW

SPOUSE'S NAME_____ SPOUSE'S OCCUPATION_____

SPOUSE'S EMPLOYER_____ NO. OF CHILDREN_____

ILLNESS ☐ OR ACCIDENT ☐ - DATE OF ACCIDENT _____

REASON FOR YOUR VISIT TODAY:

_____

_____

_____

PAST MEDICAL HISTORY

MEDICAL PROBLEMS:	SURGERIES:	DATES	MEDICATIONS: DOSAGE List all Medication you take: (Include Tylenol, AspIrin, Birth Control Pills, vitamins & herbal remedies) (include dosage & frequency):
_____	_____		_____
_____	_____		_____
_____	_____		_____
_____	_____		_____
_____	_____		_____
_____	_____		_____
_____	_____		_____
_____	_____		_____
_____	_____		_____

ALLERGIES TO MEDICATIONS _____ _____

_____ _____ _____

HAVE YOU EVER RECEIVED A BLOOD TRANSFUSION?_____EVER HAD HEPATITIS?_____

EVER BEEN TESTED FOR AIDS?_____IF YES, RESULT:_____

PHYSICAL CONDITION: Do you exercise regularly?_____ Doing what?_____

Height:_____ Current Weight:_____ Weight 2yrs. Ago_____ Are you "In Shape"?_____

SMOKING: Do you Smoke?_____ How long?_____ Packs Per Day_____

(If former smoker), Year you quit smoking _____

ALCOHOL: How often do you drink?_____ Usual number of drinks_____

Ever been treated for alcohol/drug abuse? _____

ORTHOPEDIC HISTORY

Have you ever had any of the following? (If yes, give dates below)
_____ major joint injury (ligament injury/dislocation) _____
_____ a fracture (broken bone) _____ _____ leg pain _____
_____ arthritis _____ _____ nerve/muscle injury _____
_____ back pain _____ numbness/tingling
_____ neck pain

REVIEW OF SYSTEMS – DO YOU CURRENTLY HAVE PROBLEMS WITH:

1. Dizziness _____
2. Fainting spells_____
3. Shortness of Breath_____
4. Chronic Cough _____
5. Chest Pains _____
6. Heart Palpitations_____
7. Abdominal Pain _____
8. Constipation _____
9. Diarrhea _____
10. Frequent Urination_____
11. Phlebitis/blood clots_____

FAMILY HISTORY

MOTHER: Age (or Age at death) _____ If Deceased, Cause _____
Health problems During Life _____
FATHER: Age (or Age at death) _____ If Deceased, Cause _____
Health problems During Life _____
BROTHERS & SISTERS: NUMBER OF BROTHERS _____ NUMBER OF SISTERS _____

IS THERE A HISTORY IN YOUR FAMILY OF:

1. Anesthetic Problems _____
2. Early heart attack (before age 60) _____
3. Early stoke (before age 60) _____
4. Diabetes _____
5. High blood pressure _____
6. Cancer _____
7. Bleeding Disorders _____
8. Sickle Cell Anemia _____
9. Arthritis _____

UPDATED BY PARENT/GUARDIAN	DATE:	REVIEWED DATE:
Signature:		
Signature:		
Signature:		
Signature:		
Signature:		
Signature:		